

<b>Case Number:</b>	CM14-0184344		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	10/01/2009
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional spine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 55 years old male with an injury date on 10/01/2009. Based on the 10/16/2014 progress report provided by the treating physician, the diagnoses are:1. Cervical strain2. Lumbar facet fractureAccording to this report, the patient complains of "dull and sharp, constant 7/10" neck pain that radiates to the bilateral shoulder, scapular, and upper back. The patient also complains of constant 4/10 right hip pain, and constant 7/10 low back pain with numbness in this bilateral feet and hands. Physical exam reveals pain to palpation in the right hip, cervical and lumbar spine with noticeable tremors. Right hip impingement sign is positive. Range of motion is decreased with pain. Pain is worse with stooping, bending, and twisting and "better with Voltaren gel and rest" There were no other significant findings noted on this report. The utilization review denied the request on 10/24/2014. The requesting provider provided treatment reports from 08/07/2014 to 10/16/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**ADA toilet for master bedroom:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints,Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter online for DME

**Decision rationale:** According to the 10/16/2014 report, this patient presents with constant 7/10 neck constant, 4/10 right hip pain, and constant 7/10 low back pain with numbness in this bilateral feet and heads. The treater is requesting ADA toilet for master bedroom; upon patient requests. The MTUS and ACOEM Guidelines do not address toilet; however, the ODG Guidelines states, "Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. Medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature." In this case, the treater does not mention that the patient has "physical limitations" to use a regular toilet. No discussion as to why the patient is not able to use a regular toilet and needs an ADA toilet. Examination does not show problems with leg strength or other neurologic conditions. The request is not medically necessary.

**Follow up with spine surgery for the neck:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM Practice Guidelines, 2nd Edition (2004), Chapter: 7 page 127.

**Decision rationale:** The Expert Reviewer's decision rationale: According to the 10/16/2014 report, this patient presents with constant 7/10 neck constant, 4/10 right hip pain, and constant 7/10 low back pain with numbness in this bilateral feet and heads. The treater is requesting follow up for spine surgery for neck. The utilization review denial letter states "There is no indications any previous surgery to the cervical spine or lumbar spine has been accomplished. No imaging studies were provided to be review to document any significant pathology requiring surgical intervention." Regarding follow up/consultations, ACOEM states that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. In this case, there were no exam findings, no discussion regarding any imaging studies, no reasons provided for the request. MTUS page 8 requires that the treating physician monitor the patient's progress and make appropriate recommendation. The request is not medically necessary.

**Colace 250mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Therapeutic Trial of Opioids Page(s): 77.

**Decision rationale:** According to the 10/16/2014 report, this patient presents with constant 7/10 neck constant, 4/10 right hip pain, and constant 7/10 low back pain with numbness in this bilateral feet and heads. The treater is requesting Colace 250 mg #60. Patient's current medications are Trazadone, Voltaren gel, Zanaflex, Effexor, Anaprox, Omeprazole, and Colace. Regarding constipation medication, MTUS recommends as a prophylactic treatment when initiating opioid therapy. Review of reports does not indicate the treater will initiate opioid therapy or that the patient is on opiate. There is no documentation of constipation. The request is not medically necessary.

**Trazadone 200mg, #50 dispensed on 10/16/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants Page(s): 13-17.

**Decision rationale:** According to the 10/16/2014 report, this patient presents with constant 7/10 neck constant, 4/10 right hip pain, and constant 7/10 low back pain with numbness in this bilateral feet and heads. The treater is requesting Trazadone 200mg #50 dispensed 10/16/2014. Trazodone is classified as an anti-depressant. The MTUS Guidelines on antidepressants page 13 to 17 states, "recommended as a first line option for neuropathic pain and is a possibility for non-neuropathic pain." Trazodone is also used for insomnia for patients with concurrent depression. In this case, the patient suffers from chronic neck and low back pain with no documentation of depression or insomnia. The request is not medically necessary.

**Voltaren Gel 100gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical anti-inflammatory.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Cream Page(s): 111-113.

**Decision rationale:** According to the 10/16/2014 report, this patient presents with constant 7/10 neck constant, 4/10 right hip pain, and constant 7/10 low back pain with numbness in this bilateral feet and heads. The treater is requesting Voltaren Gel 100gm . Regarding Voltaren gel, MTUS guidelines states "FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder." In

this case, the patient does not meet the indication for the topical medication as he does not present with a diagnosis for peripheral joint arthritis. In this case, the patient does not meet the indication for the topical medication as he does not present with a diagnosis for peripheral joint arthritis. The treater does not mention where it is used for either. The request is not medically necessary.